U.S. Infant Mortality Dips but Infant and Perinatal Mortality Still of Concern

■ Improvements in U.S. infant and perinatal mortality by race, age at death or length of gestation, and degree of urbanization were observed for the period 1965–73. These improvements are discussed in a recent Department of Health, Education, and Welfare publication prepared by the University of California School of Public Health, Berkeley, and the Information Sciences Research Institute, Washington, D.C. The improvements are detailed in 24 tables and 36 figures.

The publication shows that postneonatal mortality rates declined more than fetal and neonatal mortality rates. Other-than-white infant and fetal mortality rates improved more than the white rates, except for the first day of life. Postneonatal mortality rates improved more in rural than in urban areas, while neonatal and perinatal mortality rates improved more in urban areas than in rural. The improvement in infant mortality rates tended to be greatest in the States that had the highest infant mortality rates and the lowest per capita incomes in 1965. The improvement in infant mortality rates did not change the relative position of the United States in comparison with other countries.

The improvements in mortality rates were considered in relation to the changes that had occurred in the United States in economic conditions and standards of living, in medical techniques and the organization and availability of health services, and in the demographic characteristics of the childbearing population of the United States. Each of these changes was in a direction that would be expected to have a favorable effect on infant and perinatal mortality.

The authors of the study concluded, however, that despite our nation's rapid decrease in infant mortality since 1965, infant and perinatal mortality remain problems of major concern in the United States. Wide gaps continue to exist between racial groups, and the relative risk continues to be significantly greater for the other-than-white infant. Mortality varies across levels of urbanization and continues to be higher in rural than in urban counties. The wide variations among the States and among different regions of the country strongly suggest that many infant lives are still being needlessly lost.

It is hoped that programs to improve infant and perinatal mortality will be able to use the data in the study to define high-priority target groups based on the size of the problem in the target group, the severity of the problem, and the amount and direction of change.

Improvement in Infant and Perinatal Mortality in the United States, 1965–1973. DHEW Publication No. (HSA) 78-5743. Prepared under Department of Health, Education, and Welfare grants No. MC-R-60208-04 and MC-R-27020203 from Bureau of Community Health Services, Health Services Administration, Public Health Service. Single copies available from Bureau of Community Health Services, 5600 Fishers Lane, Rockville, Md. 20857.

Are Poor Children at Greater Risk of Household Injuries?

■ To clarify the relationship of lower socioeconomic status (SES) to the occurrence of injuries, a retrospective study was undertaken at the Johns Hopkins Medical Institutions. Children under 5 years of age enrolled in a prepaid HMO (health maintenance organization) serving middle to upper middle class families were compared with children of the same age who were concurrently participating in a children and youth program in an inner-city area serving primarily underprivileged children. There were emergency facilties in the buildings housing each program.

During the study period (April 1975–March 1976) the HMO had approximately 1,700 active patients under 5 years of age, while the children and youth project had approximately 3,000 children in the same age bracket.

As the chart shows, in all categories studied except fractures and dislocations, children from the HMO (that is, of higher SES) showed a greater prevalence of injuries. In the categories of "laceration" and "superficial injuries," there were a significantly greater number of injuries in the higher SES group ($P < 0.01$ based on the chi-square test). Equal numbers of children from both groups sustained fractures and dislocations. Even though children from the HMO group had more visits for burns and head trauma, the difference was not statistically significant ($P > 0.05$). When the total number of injuries was compared, the HMO had a significantly greater number of overall reported injuries ($P < 0.005$). Whether this result is artifactual, that is, reflects differences in the extent to which care was sought for injuries, is speculative. What is apparent, however, is that poor children are not, and should not, be construed as the group at greatest risk of injuries. All children from all social strata are at risk, and no groups can be complacent in their attitudes or behavior in respect to safety.

Both clinics had computerized records of all medical encounters, including visits to the emergency room. Telephone conversations, however, were not recorded. All patient records from April 1975 to March 1976 were included in the study, and records of all injuries that resulted in a medical visit were examined. To minimize assessor bias, only comparably coded injury categories for both groups of children were selected for analysis. The diagnosis of the injury had already entered the computer, so that a new injury-coded classification was not devised for the study. Because some of the children enrolled in the HMO who experienced serious ingestions went directly to tertiary care facilities, a record of these ingestions might not have been entered on their permanent HMO record. Therefore, to eliminate this known source of reporting bias, this category was omitted from the study. All other injuries perceived as severe enough to warrant a medical visit were counted. No comparison was made of the severity of injuries.

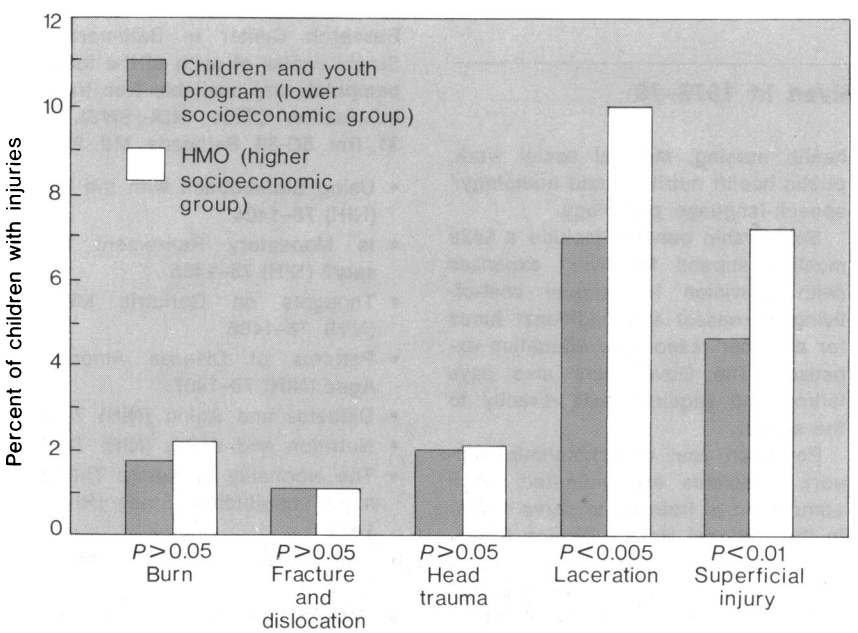
Even though the socioeconomic and demographic characteristics of the study population differ from the national statistics, the injury experience of the two study groups is roughly comparable to that in other published series, both in frequency and type of injury.

If one group cannot be singled out as being in particularly high risk of injuries, then either a single strategy for prevention must be devised that will be universally applicable, or else the content of the counter-measure must be modified so that there is greater communication with the target group.

More research is needed to elucidate further two crucial and related issues: Which factors interact to result in an injury, and how? What interventions need to be developed to reduce the occurrence of injuries? In any event, the first step in finding a solution is to assure that the magnitude of the problem is widely appreciated. Unfortunately, the subsequent steps will not be as easy.

—Robert A. Dershewitz, MD, ScM, director of ambulatory pediatrics, Michael Reese Medical Center, Chicago, Ill.

Comparison of injury experience of children 4 years old or younger from an HMO (health maintenance organization) and a children and youth program in an inner-city area, April 1975-March 1976



Note: Tests of significance are based on chi-square test.

OSHA Acts to Reduce Exposure of Workers to Benzene

■ The Occupational Safety and Health Administration, U.S. Department of Labor, has reduced the permissible worker exposure to benzene, citing evidence that the chemical causes leukemia. The new permanent standard that limits employee exposure to benzene to 1 part per million parts of air (1 ppm) averaged over an 8-hour period became effective March 13, 1978.

Assistant Secretary of Labor Eula Bingham said that the action was based on the conclusion by OSHA "that the available scientific evidence establishes that employee exposure to benzene presents a cancer danger—specifically, the hazard of developing leukemia." She added that in accord with OSHA's proposed regulatory policy regarding worker exposure to carcinogens, "this standard limits employee exposure to benzene to the lowest feasible level"—that is, 1 ppm averaged over 8 hours with a ceiling of 5 ppm for any 15-minute period during that time. The standard also prohibits eye contact or repeated skin contact with benzene—a clear, noncorrosive, highly flammable liquid.

The standard applies to all occupational exposure to benzene in all industries covered by the Occupational Safety and Health Act of 1970, including general industry, the maritime industry, and the construction industry. The standard does not apply to the sale or distribution of gasoline for fuel after it leaves bulk terminals.

The new standard requires that benzene exposure not covered by the new provisions will remain covered by the exposure level and other requirements of the present standard. The present standard sets permissible exposure at 10 ppm on an 8-hour average, with a ceiling of 25 ppm and a maximum concentration of 50 ppm for not more than 10 minutes during the 8 hours. The new permanent standard requires measurement of employee exposure, engineering controls, safe work practices, personal protective clothing and equipment, signs and labels, employee training, medical surveillance, and recordkeeping.

About 600,000 workers at about 150,000 worksites in America are expected to be affected by the new standard. Some 11 billion pounds of benzene were produced in the United States in 1976. About 86 percent is used in the production of organic chemicals, including styrene, phenol, and cyclohexane, which are used as intermediates in the manufacture of plastics, resins, disinfectants, and pharmaceuticals. The remaining 14 percent is used primarily in the manufacture of detergents, pesticides, solvents, and paint removers. Benzene also is present as a component of motor fuels, averaging less than 2 percent in gasoline.

3,340 NHSC Scholarships to be Given in 1978–79

■ About 3,340 new National Health Service Corps scholarship awards were made for the 1978–79 school year to students in 10 health professions. Some $60 million is available in fiscal year 1978 for the program administered by the Bureau of Health Manpower's Division of Manpower Training Support, Health Resources Administration.

An estimated 2,500 scholarship awards will go to medical and osteopathic students, 400 to dental students, and 160 to students in baccalaureate nursing programs accredited by the National League for Nursing. Awards also will be made to 280 master's level students in nurse practitioner training, nurse midwifery, community health nursing, medical social work, public health nutrition, and audiology/speech-language pathology.

Scholarship benefits include a $429 monthly stipend for living expenses (with provision for annual cost-of-living increases) and additional funds for all other reasonable education expenses. The Government also pays tuition and required fees directly to the school.

For each year of scholarship support, recipients are obligated, upon completion of training, to serve 1 year in the National Health Service Corps, assigned to a full-time clinical practice in a health manpower shortage area. The minimum service obligation is 2 years.

New York City Symposium on Nutrition and Gastroenterology

■ The Institute of Human Nutrition at Columbia University is sponsoring a 2-day symposium on nutrition and gastroenterology in New York City, November 30–December 1, 1978. Dr. Myron Winick, director of the Institute of Human Nutrition, will serve as chairman of the symposium.

The symposium, involving international experts, will cover basic research in gastrointestinal physiology under different nutritional conditions. In addition, it will explore the relation of nutrition to gastrointestinal diseases and the effect of diseases of the gastrointestinal tract on nutritional status. Finally, nutritional therapy for patients with specific gastrointestinal diseases will be discussed.

For further information, write Director, Institute of Human Nutrition, Columbia University, 701 West 168th St., New York, N.Y. 10032.

Pamphlets on Research on Aging and the Elderly

■ The National Institute on Aging now has available summaries of presentations given at a State of the Art Seminar on Aging Research held October 1, 1976, at the Institute's Gerontology Research Center in Baltimore, Md. Single copies of each of the following pamphlets are available free from the Information Office, NIA-(SWS), Bldg. 31, Rm. 5C-36, Bethesda, Md. 20014:

- Using Biofeedback with the Elderly (NIH) 78–1404
- Is Mandatory Retirement Necessary? (NIH) 78–1405
- Thoughts on Geriatric Medicine (NIH) 78–1406
- Patterns of Disease Among the Aged (NIH) 78–1407
- Diabetes and Aging (NIH) 78–1408
- Nutrition and Aging (NIH) 78–1409
- The Normality of Aging: The Baltimore Longitudinal Study (NIH) 78–1410
- Drugs and the Elderly (NIH) 78–1449
- Aging: Genetics and the Environment (NIH) 78–1450.

FDA and EPA to Cooperate in Audits of Pesticide Testing of Commercial Laboratories

■ The Food and Drug Administration (FDA) and the Environmental Protection Agency (EPA) have signed an agreement to cooperate in auditing animal safety tests performed by commercial laboratories of farm, home, and industrial pesticides.

The program is designed to avoid duplication between FDA and EPA in inspecting laboratories and auditing tests and to provide a single standard for laboratory performance. Previous investigations by the two agencies have raised questions about the accuracy of the animal tests that were used to support the Federal Government's approval of pesticides and other regulated chemicals. The audits are to assure the tests' validity.

Under the terms of the agreement, FDA will audit the animal tests that EPA requests and report its findings. EPA will determine whether any discrepancies challenge the validity of the studies and, if so, whether regulatory action is warranted.

During 1978, FDA will audit pesticide tests conducted by approximately 70 laboratories. Inspection of these laboratories will be incorporated into FDA's program of inspection of laboratories that test foods, drugs, and other FDA-regulated products. The two agencies have been cooperating informally on laboratory audits for several months. So that the laboratories will not be alerted to the inspections in advance, the list of those that are to be inspected is not being released.

The cooperative program is part of an across-the-board effort by FDA, EPA, the Occupational Safety and Health Administration, and the Consumer Product Safety Commission to share knowledge and resources in controlling toxic substances. FDA currently is also negotiating similar cooperative laboratory inspection programs with the Occupational Safety and Health Administration and the Consumer Product Safety Commission.

The agreement, signed by FDA Commissioner Donald Kennedy and EPA Administrator Douglas Castle, appeared in the Federal Register on April 4, 1978.

Meeting the Needs of Abused and Neglected Adolescents

■ Demonstration projects to develop low-cost innovative services for abused and neglected adolescents within a protective service setting have been funded by the National Institute of Mental Health of the Department of Health, Education, and Welfare's Alcohol, Drug Abuse, and Mental Health Administration, in collaboration with the Administration for Children, Youth, and Families of the Department's Office of Human Development Services.

Since 1975, significant levels of abuse and neglect among the adolescent population have been noted by NIMH and brought to the attention of the public and mental health professionals. The demonstration projects are designed to develop models to increase the level of service within those protective services that provide the major points of entry by adolescents into the helping systems.

Three projects have been funded, each representing a different model:

1. Prince George's County, Hyattsville, Md., Department of Social Services awarded $31,382. Two youth specialists will be placed in the child protection intake unit. They will work with the county's present child abuse and neglect process, consulting with the local child abuse protection team and its associated mental health professionals. 2. Community Guidance Center, Bexar County, San Antonio, Tex., awarded $23,658. The project will offer mental health consultation to Bexar County's social services through a mental health consulting team that will work with a local child abuse coordinating team. The mental health consulting team will discuss case management with protective service personnel and assist in expediting services to high-risk teenagers. 3. Ramsey County Department of Mental Health, St. Paul, Minn., awarded $32,174. This project will provide an adolescent specialist to work within the protective service system at the intake level. The specialist will be affiliated with both social service and mental health units concerned with child abuse and neglect, will handle specific cases, and will be available to the protective service workers for consultation.

Further information on all projects may be obtained from Ira S. Lourie, MD, Deputy Chief, Center for Studies of Child and Family Mental Health, Division of Special Mental Health Programs, National Institute of Mental Health, Rm. 11A-16, 5600 Fishers Lane, Rockville, Md. 20857; telephone (301) 443-4688.

Rapid Inflation Causes Community Hospitals to Cut Back on Services

■ Rapid inflation in health care costs has been found to have a special impact on community hospitals, particularly public hospitals, which has resulted in significant cutbacks in services. Two related studies, supported by the National Center for Health Services Research (NCHSR), Health Resources Administration, were conducted to determine if rising unemployment during the 1974–75 recession had resulted in increased use of hospital outpatient and emergency services, particularly in the urban public hospital.

The findings indicate that the use of services did not increase during unemployment, but that community hospitals did suffer severe financial hardships necessitating unwanted reductions in services. Public community hospitals, especially, were hard hit by the recession because of the cities' inability to provide sufficient funds to cover the hospitals' increased costs. The private community hospital, with independent sources of capital and revenues, was better able to withstand the economic pressures.

Trends in Facility Use: An Evaluation of the Impact of Adverse Economic Conditions on the Health Status of the Poor, by Policy Analysis, Inc. (order No. PB 273 313) and Study on the Impact of National Economic Conditions on Health Care of the Poor (Utilization), by Columbia University (order No. PB 263 341). Copies available from the National Technical Information Service, Springfield, Va. 22161 (703/557-4650).

Live Human Cell Bank Established for Aging Research

■ Because cells and extracellular substances are organized into tissues and organs of the body, studies at the cellular level offer great opportunity to advance knowledge of human aging and ultimately improve the health of older people. Recognizing the need for such research, the National Institute of Aging (NIA), National Institutes of Health, has developed a unique resource for scientists conducting gerontological studies—a bank of live human cells in culture. Through a contract with the Institute for Medical Research (IMR) in Camden, N.J., the NIA establishes, characterizes, stores, and distributes standard and genetically marked human cell lines for aging research.

Cell Bank's Special Resources

The repository at the Institute for Medical Research houses four types of cultured human cell lines. These include: (*a*) human cell lines derived from normal persons (from fetal to old age); (*b*) strains of cells derived from persons with abnormal growth disorders such as progeria (premature aging); (*c*) cells derived from originally normal lines transformed by virus infection, and (*d*) cell lines derived from persons at high risk of cancer. Detailed information on in vitro cellular aging can be obtained by studying cells that range in activity from a normal rate of proliferation to an accelerated rate of division to the never ending, cancerous form of cell growth.

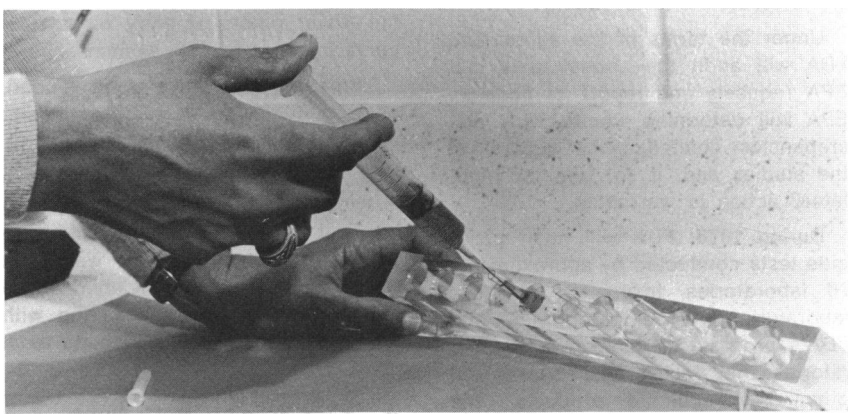
Several years ago the National Institutes of Health supported the development of a human diploid (containing 46 chromosomes) cell strain that subsequently became the cell line of choice for aging research. This cell line, named WI-38, has since become relatively limited for purposes other than vaccine manufacture. Realizing the need for a human diploid cell line for scientific research, NIA commissioned IMR to establish a new line of cells that would closely resemble WI-38. IMR-90 is just such a line. It was derived from female embryonic lung tissue and closely parallels WI-38 to provide interchangeability with WI-38 in ongoing cellular aging experiments. The extensive frozen stock of IMR-90, combined with a carefully planned distribution protocol, enhances the long-term availability of these cells to research scientists.

Under NIA direction, the Institute for Medical Research has also established another new "normal aging" cell line called IMR-91. Derived from human male embryonic lung tissue, IMR-91 is also available on a long-term basis. In the near future, animal cell lines appropriate to aging research also will be made available through the NIA-IMR cell bank.

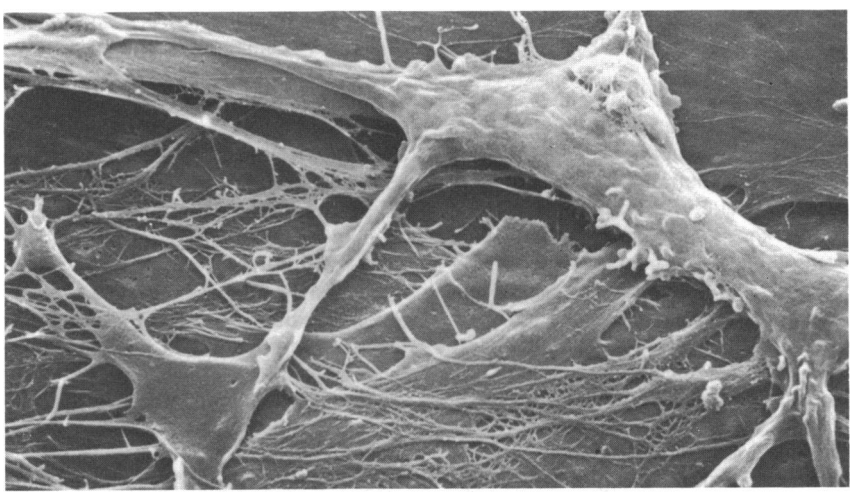
At IMR, cultured human cells are frozen in liquid nitrogen at minus 316° F. when they are at low passage —that is, when they are relatively "young" and hold the promise of many more divisions for the researcher to observe before they cease dividing in culture. Advantages to investigators using cells from this repository include the assurance of a well-characterized human cell line that has been checked extensively and found free of microbial contamination. From the time of biopsy to the time the cells are frozen, they are handled in a carefully controlled, sterile environment and are checked repeatedly for the presence of mycoplasmas, which are possibly the most evasive cell culture contaminants of all.

Additional Services of the NIA

The NIA has established a facility for detection of mycoplasmas. Smaller than bacteria but larger than viruses, these organisms often contaminate cell cultures, and if undetected, tend to skew or invalidate research results. Researchers can mail in samples of their cultured cells for mycoplasma detection.



From each passage (harvest) of cells, approximately 500,000 daughter cells are planted, and a new passage is seeded. Also, at the end of each harvest a portion of cells are centrifuged and placed into ampules with a syringe. Each ampule is filled with approximately 500,000 cells



A scanning electron micrograph by Dr. John E. Johnson, Jr., NIA, showing IMR-90 cells at magnification of 15,000

Five Hospitals to Install Solar Hot Water Systems

■ Five hospitals will install experimental solar energy hot water systems under contracts announced recently by the Department of Health, Education, and Welfare (DHEW). Total costs of the projects is $906,065, of which the Federal funding is $573,581.

The projects were selected from among 75 proposals for solar energy systems received by the Department in a national competition announced in the summer of 1977. Dr. Henry A. Foley, Administrator of DHEW's Health Resources Administration, pointed out that the contracts are part of the agency's effort to prepare health care facilities to cope with future shortages of natural gas or oil without disruptions in the services they provide to patients.

The five solar energy contracts are administered by the Health Resources Administration, with funds transferred from the Department of Energy through an interagency agreement; Dick K. Riemensnider is project officer.

The largest project is a 6,358 square foot solar collection system that will heat 28 percent of the hot water needed for the laundry of the 712-bed Wesley Medical Center in Wichita, Kans. Its total cost is $300,360, of which the Federal Government will pay $150,180.

Santa Clara Medical Center, a 318-bed facility in Santa Clara, Calif., will use a 2,402 square foot collector system to meet 30 percent of its hot water requirements. The project's cost is $203,115, of which a Federal contract covers $132,085.

More than a third of the hot water requirements of the 97-bed Hurst-Euless-Bedford Hospital in Bedford, Tex., will be met by 2,500 square feet of solar collectors. This Texas project will cost $187,287, of which $140,465 will be covered by the Federal contract.

One of the other two contracts is with St. Mary's Hospital, Rhinelander, Wis., (150 beds), which will use 1,800 square feet of collectors. The project will cost $109,043, of which $81,782 will be covered by Federal funds. The other contract is with Dayton Children's Psychiatric Hospital, Dayton, Ohio (65 beds), which will use an 850 square foot collector system. The project will cost $106,260, of which $69,069 will be covered by the DHEW contract.

Factors in Eliciting "Good" Respondent Reporting in Health Survey Interviewing

■ Improved interviewing techniques can significantly increase the quality of health survey data, according to the results of a study conducted by the Institute for Social Research of the University of Michigan. Supported by the National Center for Health Services Research (NCHSR), Health Resources Administration, investigators experimented with various interviewing techniques to identify the factors that were important in obtaining "good" respondent reporting. An exploration of variations in interviewer behavior and question-wording revealed that interviewers contributed largely to reporting bias. The most surprising observation was that interviewers indiscriminantly gave positive feedback for both good and poor respondent behavior. To test the potential for improved effectiveness, researchers used various instruction, feedback, and commitment techniques, singly and in combination, in field interviews. The combined use of the three techniques proved to be the most effective, permitting the researcher to assume close control over the interview process and thus reducing the variability in data due to interviewer differences.

Experiments in Interviewing Techniques: Field Experiments in Health Reporting, 1971-1977. DHEW Publication (HRA) 78-3204; November 1977. Single copies available from NCHSR, Rm. 7-44, 3700 East-West Hwy., Hyattsville Md. 20782 (301/436-8970).

Nine Alcohol Research Centers Designated by NIAAA

■ Four new alcohol research centers have been established with grants from the National Institute on Alcohol Abuse and Alcoholism (NIAAA), Department of Health, Education, and Welfare. The newly designated centers, the areas of research they will pursue, and the amounts of the awards for the first year follow:

- Rutgers University, State University of New Jersey—The Etiology of Alcoholism—$322,718
- University of Columbia, Irvine—Effects of Ethanol on the Central Nervous System—$269,431
- University of California, Los Angeles —Effects of Alcohol on the Central Nervous System—$204,293
- University of Connecticut Health Center—Center for the Study of Alcoholism—$200,543

There are now nine NIAAA-supported alcohol research centers. Previous grants for centers were to:

- University of California, Berkeley, School of Public Health—Epidemiology of Alcohol Problems—$364,771
- University of Colorado, Boulder, Colorado—Genetic Approaches to Neuropharmacology of Ethanol—$386,285
- Mount Sinai School of Medicine of the City of New York—Pathologic and Toxic Effects of Alcohol—$377,900
- Salk Institute for Biological Studies, San Diego, California—Central Nervous System Effects of Alcohol: Cellular Neurobiology—$497,668
- Washington University—School of Medicine, Department of Psychiatry, St. Louis, Missouri—Neurobiology, Generics, Epidemiology, and Alcoholism—$373,276

The research center grants program complements the regular research grants program of the Institute by providing long-term support for interdisciplinary research programs with a focus on a particular research theme relating to alcoholism and other alcoholism problems. The grants were awarded under Section 504 of the Comprehensive Alcohol Abuse and Alcoholism Treatment and Rehabilitation Act of 1970 as amended (42USC 4588), which authorizes Congress to appropriate up to $6,000,000 annually for fiscal years 1977, 1978, and 1979.

Study of Early Treatment for Diabetic Retinopathy

■ A new nationwide clinical trial of early treatment for diabetic retinopathy, a common eye complication of diabetes and a leading cause of blindness in the United States, has been announced by the National Eye Institute.

Investigators in the Early Treatment for Diabetic Retinopathy Study (ETDRS), in which 22 research centers are involved, will examine the use of laser and drug treatment.

Data from a previous NEI-supported trial, the Diabetic Retinopathy Study (DRS) *(Public Health Reports,* July–August 1976, page 388), showed that laser treatment can reduce the risk of blindness in patients in the proliferative stage of the disease. However, some patients became blind in spite of treatment, and in some, harmful side effects were noted—mild blurring of vision and narrowing of side vision. The new study seeks to determine whether treatment at an earlier stage of retinopathy may be of greater value in reducing the risk of blindness, and if so, whether this benefit outweighs the risk of adverse side effects.

Investigators in the ETDRS also hope to find out whether laser treatment is effective against macular edema, an abnormal accumulation of fluid in the retina that frequently accompanies diabetic retinopathy and may cause blurred central vision.

A third objective of the study is to determine whether aspirin, alone or in combination with another drug, is useful in treating diabetic retinopathy. Because aspirin interferes with the clumping of blood platelets, it may be effective in preventing blockage of the retinal vessels in diabetic retinopathy.

Patient enrollment in the new ETDRS will begin after a planning stage of 1 year. Eventually 3,000 patients are expected to participate. It is expected that each will be followed for 5 years so that long-term information can be obtained on the risks and benefits of both kinds of treatment. The estimated average yearly cost of the projected 7-year to 8-year study is $3 million. Through an interagency agreement, the Center for Disease Control in Atlanta, Ga., plans to provide a central laboratory for the study to monitor drug treatment of patients.

Report Issued on the Future of Public-General Hospitals

■ The nation's public-general hospitals are indispensable to the delivery of essential health care services to millions of Americans and should be maintained and improved as valuable health service resources. This is the major conclusion reached by the Commission on Public-General Hospitals, a nongovernmental study group that recently completed a 2-year examination of the 1,905 general hospitals owned by State and local government —one-third of all community hospitals in the nation.

To enable these hospitals to continue in their vital role, their governance and management capabilities must be improved and their financing strengthened, says the Commission in a report issued recently. In particular, the enormous problems of public-general hospitals in the nation's largest cities must be given immediate attention, including Federal fiscal relief, if these hospitals are to continue to provide care for the large numbers of patients that they serve.

The Commission on Public-General Hospitals was established in February 1976 by the Hospital Research and Educational Trust through grants from the Robert Wood Johnson Foundation, Princeton, N.J., and the W. K. Kellogg Foundation, Battle Creek, Mich. Additional support for a conference program was provided by the Cleveland Foundation, Cleveland, Ohio. The Commission's purpose was to make a critical and objective examination of the role of public-general hospitals in the delivery of health services and to identify the needs and prospects for change. The independent study group was composed of 17 members from hospital and health care administration, medical education, and State and local government.

The Commission's report, "The Future of the Public-General Hospital: An Agenda for Transition," calls for changes in the service delivery roles and the governing structures of the public hospitals to enable them to accommodate to governmental pressures for cost containment, to the planning and development of regionalized health systems, and to the reform of the system of financing health care, including the enactment of some kind of national health insurance.

The agenda oulined by the Commission includes the following major findings and policy recommendations:

- Even with eventual development of a program of national health insurance, local government will continue to have important health care delivery roles, including ensuring access to health services for all community residents and making available the needed services that private hospitals cannot or do not provide.
- It is no longer appropriate for public hospitals to serve only the poor. They must be broad-based community resources, providing essential services that contribute to continuity of individual and family health care within rationally planned and organized community health care delivery systems.
- It is essential that public policy recognize the continued need to support the public hospitals' health professions education and research roles out of concern for both the quality of medical education in this country and the quality and quantity of care.
- The public-general hospitals must establish more efficient governance and management capabilities that will enable them to reconcile public accountability with management flexibility and to work with the community, other health care providers, and planners and regulators.
- The Commission recommends specific measures for providing immediate fiscal relief to those hospitals that serve large numbers of indigent patients. At the same time, the programs that provide funds and care for people who are unable to pay must be reformed and restructured so that less of the burden of caring for the poor will rest on the local tax bases. Changes are recommended for private insurance and other third-party payment plans to create incentives for hospitals to provide appropriate care that will minimize the need for inpatient services and that will establish payment rates for comparable hospital services, regardless of the hospital's ownership.

The Future of the Public-General Hospital: An Agenda for Transition. Free copies from Hospital Research and Educational Trust, 840 North Lake Shore Dr., Chicago, Ill. 60611. A companion volume, Readings on Public-General Hospitals (papers and transcripts of speeches prepared for the Commission's seminars and meetings) is available, $15 per copy.